

**ANGLOPHONE CANADIAN-BORN WORKING-CLASS WOMEN IN
ELDERCARE**

by

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ABSTRACT

This practicum report explains my work experience in a long-term care facility under the supervision of a social worker at Extendicare Bayview in Toronto, Ontario. The primary feature of this report is to gain an in-depth understanding of the challenges of living in a long-term care home, specifically for white Anglophone Canadian-born working-class women. This report features three interviews with three women of the above noted ethnicity and background in an effort to determine what helps make their experiences in long-term care positive, as well as what hinders their well-being. With their written consent, this information was obtained by conducting informal interviews as well as by communicating with residents, their families, and staff and by performing social work duties under the social worker's supervision. Pertinent conversations were preserved in a journal kept only by me. It was concluded, based on my interviews, that loss of independence and limited privacy hindered the well-being of these residents, while activities performed in the home helped their well-being. Recommendations for social work practice with the elderly conclude this report.

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Anglophone-Canadian-Born Working-Class Women in Eldercare

Chapter One: Introduction

An ageing population is a fact of life in Canada. In fact, 1, 685.7 people in Ontario alone are over the age of 65 (Statistics Canada, 2006). Many of those in this ageing cohort are white Anglophone-Canadian-born working-class women living on a low-income and suffering from a series of network losses involving friends, family, employment, and issues related to loss of independence (Gatz, 1995). During the 1990s, health reform cutbacks shifted patients from hospitals into long-term care facilities. This move has been accompanied by an increase in private ownership of nursing facilities. Further, women comprise the majority of caregivers to their terminally ill partner, often leaving them with inadequate resources to utilize in the provision of this care. This often results in women having to use their savings to provide care to their partner, leaving them with little funds to rely on in the provision of their own care. For instance, a report published by the Canadian Association of Social Workers (CASW), entitled *Financial Security for Women Seniors in Canada* (2007), revealed that women are presently encountering exceptional financial vulnerability. Although the Canadian government has made significant improvements to the economic stability of seniors, the low income rate among senior women continues to increase. In fact, the income rate among senior women was twice as low as it was for men in 2006 (CASW, 2007). Further, more than 20% of single senior women are living on a low income.

According to a report published by the Status of Women Canada (2004), women comprise 80% of informal caregivers. Women's unpaid and informal labour in the healthcare

system is increasing, as hospital cutbacks are sending patients home “sicker and quicker” (Hankivsky, Morrow, Armstrong, Galvin, & Grinvalds, 2004, p. 13). Considering that women tend to live longer than men, and are statistically more likely to be both the recipients and the providers of services to the elderly, there is need for a comprehensive examination regarding women in particular, when it comes to the plethora of issues affecting this population, specifically issues of long-term care accessibility and satisfaction (Weinberg, 2000). In fact, in December 2001, nearly 30, 000 long-term care beds were wait-listed in Ontario alone (Ontario Health Coalition, 2007). This waiting for care is unfavourable to the health and well-being of women in need of nursing care.

Another important factor requiring exploration is the fact that women have historically been silenced by the very institutions which are expected to ensure their rights. Taking into consideration that elderly women in nursing facilities are often from a generation that condones the suppression of women’s voices, they may be less likely to demand the same quality of care afforded to elderly men. This is an important issue for healthcare providers as government acts, bills, policies, and procedures not only affect women receiving long-term medical care, but also those providing such care:

Women are the front-line providers of formal and informal long-term care, and they draw disproportionately on the services of long-term care. In rural communities, nursing homes offer job opportunities, but have also been pointed to as sites of abuse, of unstable, low-paid jobs, and as suffering some of the worst impacts of health care underfunding and restructuring. Long-term care policy thus affects women employed

in the sector and the lives of the largely female, increasingly aging population in need of care (Status of Women Canada, 2007, p. 1).

These factors alone make long-term care an important women's issue. It is important to note that long-term facility-based care is not publicly insured under the Canada Health Act. It is administered by provincial and territorial legislation, thus differing across the country and resulting in inconsistent standards nationwide. An argument exists surrounding the creation of a two-tiered healthcare system, wherein, those with the funds to do so may purchase healthcare of their choice privately, at centres such as Extendicare, and those without the means to do so can have their long-term care costs covered at locations funded by their provincial government.

Chapter Two: Description of the Practicum Setting & Practicum Objectives

Extendicare Bayview is a privately-owned 203-bed long-term care centre located in north Toronto, and is (voluntarily) accredited by the Canadian Council on Health Services Accreditation. Their mission statement is as follows: “At Extendicare Bayview, we understand that each resident’s quality of life depends on an approach to care that combines input from residents and family members, with individual assessments from a team of trained caregivers. This approach ensures that support and care is tailored to meet the needs of each unique individual” (Extendicare Bayview, 2008). They first began in 1968 with a federal charter under the name Pendexcare Ltd. to operate as a supplier of long-term care services in Canada with “an aim of helping to relieve an overburdened hospital system” (Extendicare, 2008). In the same year, Pendexcare changed its name to Extendicare (Canada) Ltd. In 1969, Extendicare purchased its first long-term care home in Ottawa, Ontario, and began construction on four facilities in the province. In 1974, Extendicare (Canada) Ltd. changed its name to Extendicare Ltd. (Extendicare, 2008). Today, they employ a multi-disciplinary team of 24-hour nursing, physicians, dietary and support services, social work, recreation and physiotherapy. Their social worker assists individuals and their families “to become acquainted and accustomed to this new living environment” (Extendicare Bayview, 2008). The social worker offers supportive counselling, information and education with regard to adjustment, psychosocial issues, financial issues, and referrals to appropriate community resources: “social work services strive to enhance the quality of life of all those who live, visit and work at Extendicare Bayview” (Extendicare Bayview, 2008).

The main objective of this practicum, which took place at Extendicare Bayview, was to gain an in-depth understanding of the critical issues affecting white, Anglophone-Canadian-born working-class women in eldercare, specifically, what attributes help with a positive experience in a long-term care facility. My further objectives will be discussed in more detail later in this report.

I had a series of informal conversations with 3 women to collect their thoughts, views, opinions, and experiences as residents of long-term care. They were lucid. If they suffered from any mental health issues (e.g., Alzheimer's, Dementia, etc.), they were not suitable for this project. I compared and contrasted their experiences within a feminist framework of social work practice. My practicum supervisor at Extendicare, Marcy Turkel, MSW, selected the appropriate women from a pool of her clientele. I provided the candidates with a clear, concise description of the research component of my practicum in an Information Sheet (Appendix A). Confidentiality was discussed and attained through Letters of Consent (Appendix B) prior to the research commencing. There is a significant gap in the literature regarding women in long-term care facilities. Thus, this research may be important for development of future programs, policies, and practices which improve existing long-term care services for elderly women residing in such facilities.

Duration of this practicum was approximately 18 weeks (or 560 hours) starting on May 12, 2008. The practicum learning objectives were as follows:

1. To gain an in-depth understanding of the critical issues affecting white, Anglophone-Canadian-born working-class women in eldercare;

2. To achieve a greater understanding of the attributes that help women maintain a positive experience in a long-term care facility;
3. To explore some of the challenges of adapting to life in a long-term care setting;
4. To explore some of the factors these women might like to change to make their experience in long-term care more satisfactory;
5. To increase my awareness of the role of social work in the field of gerontology;
6. To become familiar with the range of psychosocial issues affecting elderly residents in long-term care.
7. To experience, learn, and compare my own experiences as a white Anglophone-Canadian-born woman from a working-class background, with that of women from the same racial/socioeconomic status. This will be accomplished by sharing my own experiences and stories and contrasting them with that of the women I will be interviewing.
8. To consider these challenges of transition within a feminist framework of social work practice.
9. To complete the literature review of long-term care centres and elderly women's experiences in such facilities.
10. To make recommendations for social work education, policy, practice, and research in this area.

Chapter Three: Literature Review

Statistics of Ageing

As previously noted, there are significant gaps in the literature pertaining to elderly women in long-term care, demonstrating a need for research in this area. Moreover, the literature that does exist is primarily based on American research, statistics, and worldviews, or focuses on women as caregivers as opposed to the recipients of care. With that in mind, American demographics can be applicable to Canadian demographical figures of ageing. For instance, the number of Americans aged 65 and older increased from 3.1 million in 1900 to 35 million in 2000 (Richardson & Barusch, 2006). In Canada, the 2001 Census showed that seniors aged 65 or over accounted for 13% of the nation's population, up from almost 12% in 1991. Projections indicate this fraction will reach 15% by 2011 (Statistics Canada, 2001). Further, those aged 80 and over are the group growing at the fastest pace. From 1991 to 2001, their numbers climbed 41.2% to 932,000. The number of people aged 80 or over is expected to increase an additional 43% from 2001 to 2011 (Statistics Canada, 2001). The census also enumerated 3,795 people aged 100 and over in 2001, compared with 3,125 in 1996, a 21% increase. Among these individuals, 3,055 were women and 740 were men. They were distributed among the provinces in just about the same proportions as the total population: 36% lived in Ontario, 21% in Quebec and 14% in British Columbia (Statistics Canada, 2001). Such data is crucial in the examination of Canada's long-term care centres, as funding, overcrowding, and lengthy wait-lists affect accessibility to such facilities.

Kaden and McDaniel (1996) note that women in Canada are the primary consumers of long-term care because they have more chronic health problems and live longer than men.

They argue that several aspects of the ageing process are in particular *women's issues*.

However, research on ageing has neglected to give attention to gender differences in the course of growing old. It is probable that older women are more likely than older men to be impoverished, widowed, living alone, receiving aid from both formal and informal supports, as well as being institutionalized in long-term care facilities.

Long-Term Care Research and Policy Formulation

Patricia McKeever, Faculty of Nursing, University of Toronto, analyses current long-term care policies in Canada using key aspects of critical social theory. She delves into the ubiquitous pattern of gender inequalities in terms of caregiving both in the home and in institutions. She states that she relies on critical social theory because its foundation is “at odds with the traditional view of science from which the policy advisory process usually draws authority” (p. 200). McKeever (1996) contends that Canadian social welfare policies have overhauled the healthcare system, resulting in drastic work restructuring. Such work reallocations have been particularly dramatic in the growing area of long-term care. The author also argues that medical, technological, and pharmacological advances have led to increased rates of chronic illness and disability. Combine this with the increase in the number of frail elderly and more people than ever are requiring long-term care.

Current Canadian social policies have evolved from a combination of privacy-oriented and collective traditions. According to McKeever (1996), since the 1980s, the dominant policy goal has been to decrease federal and provincial deficits. It is no secret that Canada has one of the most expensive (and possibly valuable) publicly-funded healthcare systems in the world. Thus, both the federal and provincial governments have shifted

responsibility from the healthcare and social welfare system to that of the family in terms of long-term caregiving responsibilities.

It is important to note that each province's long-term care policies differ, with Manitoba having an unsurpassed standing in long-term care policy initiatives. However, regardless of which province one resides in, existing policies continue to cultivate gender inequalities, resulting in profound dependence on the unpaid labour of female family members. In terms of policy, the incidence of unpaid family caregiving results in reduced eligibility for services and benefits for the recipient of the care. The growth of women's caregiving responsibilities to include unpaid domestic labour masks the actual costs of healthcare in Canada and of many Western societies. Current long-term care policies do not take into account the interface between the economic and structural conditions of women's lived experiences, while simultaneously devaluing the work they provide (both in and out of the home). If the government is to be fair, long-term care policy options must extend to incorporate the gender component of family caregiving and the effect that these policies have on the women who provide such care.

Long-Term Care Coordination: Lessons From Manitoba?

In Canada long-term care coordination, the process of assessment and care coordination, efficiently runs the current system of long-term care. Celia Berdes (1996) discusses the long-term care system in Manitoba, its philosophy of care, values, and policy achievements. She purports that of all the Canadian provinces, Manitoba is the most progressive in providing comprehensive, coordinated, long-term care that "truly merits the characterization of a system" (p. 168). Manitoba has the minimum attributes of such a

system: the commitment of both the federal and provincial governments to the health and social care system; a concrete base of information about the elderly population; it had established satisfactory administrative infrastructure and service delivery; it had well-established and integrated systems of care in related sectors, which support the long-term care system; it had established centres of research in the area of health services to monitor the effectiveness of the long-term care system.

What may be most significant about Manitoba's long-term care system is its two processes: client needs assessment and care coordination, a system referred to collectively as case management. Care coordination in Manitoba is not simply an eligibility or cost-control function; it is an assessment for care and care coordination function. Care coordinators and needs assessments combine to determine the total need for service, thus keeping the elderly person at home as long as possible. The effort of the interdisciplinary team that gauged the individual's need for long-term care contributed comprehensive information about their ability to function in the community. Berdes (1996) asserts that by "crossing boundaries", Manitoba's care coordination and needs assessment system has contributed to innovation in the system of homecare and long-term care and should serve as an example to other provinces, including Ontario (p. 170). Ontario has also been progressive in addressing the long-term care needs of their elderly. This is due in large part to the fact that Ontario's recent healthcare reform has coincided with Britain's attempt to reform the system through comprehensive legislation (Litwin & Lightman, 1996). In Ontario, Community Care Access Centres (CCAC) are the primary points of contact for accessing admission into long-term care facilities, as well as for arranging homecare services. Currently, there are 14 CCACs across Ontario and are funded by Local Health Integration Networks through the Ministry of

Health and Long-Term Care. CCAC services are covered by the Ontario Health Insurance Plan (OHIP).

Long-Term Care Funding

According to the Canadian Mortgage and Housing Corporation (2010) fees range from \$1,000 to \$4,500 per month, with the average cost being \$2,190, making the standard cost for one year in a long-term care facility in Canada \$26,280 (Comfortlife, 2010). In Ontario, the annual cost for one year in a nursing facility is \$19,370 for a basic/standard room. For a semi-private room the cost increases to \$22,284 yearly and to \$25,932 per annum for private accommodations (Ontario Ministry of Health and Long-Term Care, 2009). The provincial government provides a subsidy for residents who are unable to pay the resident co-payment. In Canada, long-term care is provincially-regulated, funded by the public on a cost-sharing basis with residents (Ontario Long-Term Care Association, 2008). In Ontario, the province pays for approximately two-thirds of the entire cost of accommodations and the residents in around one-third of the total cost. The government decides how much funding will be provided to homes each year, adjusting the co-payment based on inflation rates, making it the same rate for each home across the province (OLTCA, 2008). Those without the means to pay the full cost of standard accommodation may apply for a rate reduction. Residents with low incomes who qualify for the maximum co-payment rate reduction receive a Comfort Allowance of \$122 as of November 1, 2007 (OLTCA, 2008).

Economic Issues and Canadian Women

In terms exploring Anglophone-Canadian-born working-class women in eldercare, the literature is scarce. What was attainable, however, was an in-depth report by Hankivsky, Morrow, Armstrong, Galvin, and Grinvalds (2004), regarding elderly women in Canada, entitled *Trade Agreements, Home Care, and Women's Health*. This report, published by Status of Women Canada, provides a thorough analysis into the issues affecting women in Canada, particularly emphasising women as caregivers, their economic contribution in both the public and private realms, their disproportionate consumption of pharmaceuticals worldwide, and elderly women's financial vulnerability. Often, elderly couples spend their savings to care for the older male spouse. When the time comes for the provision of care for the female spouse, the savings have been spent (Hankivsky et al., 2004). The situation is direr for working-class elderly women, as every dollar they earn goes to their daily living expenses. Rent, food, utilities, transportation, and various costs of daily living (toiletries, etc.) are accounted for and not necessarily put aside into a savings plan for the provision of their long-term care needs (Hankivsky et al., 2004).

According to the Canadian Women's Health Network (CWHN, 2010) more than 75% of long-term care residents in Canada are women. Moreover, women comprise 90% of the direct caregivers (professional support workers, physical and occupational therapists, registered and practical nurses, as well as support staff: laundry, cleaning and clerical staff) working in long-term care homes. Further, most of residents' visitors are female family members (CWHM, 2010). Women outnumber men in long-term care centres not only because there are a disproportionate number of elderly women than men, but also because women live longer than men and, as noted earlier, a greater percentage of elderly men tend to be married as compared to elderly women (Holosko & Feit, 2004).

The typical long-term care resident is an “82-year old widowed female suffering from an average of four illnesses” (Holosko & Feit, 2004, p. 208). These illnesses include diseases of the circulatory system, mental disorders and senility without psychosis, endocrine and nutritional metabolic diseases, and neoplasms, including cancer (Holosko & Feit, 2004). Although not all of these conditions render the individual incapable of caring for themselves, even when coupled with old age, for elderly widows with the financial means to do so, many prefer to reside in a long-term nursing facility than burden family members with requesting care (Holosko & Feit, 2004). The same authors note that although “nursing homes” have been labelled as a place to go when people can no longer care for themselves, and where these people ended up when their families abandoned them, today emphasis is on living rather than dying and on helping a person become “as independent as possible in order to return to one’s own home...” (Holosko & Feit, 2004, p. 208).

Women and the Cost of Caregiving

Medjuck, O’Brien, and Tozer (1992) investigated the relationship between women’s caregiving responsibilities to their elderly kin, their paid employment, and the seeming unconcern of policy to the high costs sustained by the women providing such care. According to the authors, this is an issue in dire need of attention, as caregiving to the elderly is one of the most crucial issues facing Canadians today. Further, little research exists regarding the circumstances of family members providing such care, including the costs related to this encumbrance. What is often termed a “labour of love” is viewed by policy makers as a “duty” bestowed upon those providing the care and, therefore, not necessarily a government responsibility (p. 44). Ideologically, the provision of care *should* be an act of

of preschool children and two-thirds of mothers of school-aged children were employed (Medjuck et al., 1992). Although the nature of the Canadian labour market has changed significantly in recent years, many of these women with school-aged children are also said to be expected to provide care to elderly kin if necessary.

The possible cost of caregiving to elderly kin is wide ranging and is experienced differently according to social, economic, employment, and family circumstances of the caregiver. Caregiving for an elderly relative may incur expenses in terms of heating, medical supplies, particular foods and diets, transportation, housing, and supports workers to assist with activities of daily living (ADL).

In essence, care to elderly kin has imitated the ideological and textual basis upon which all women's work is rationalized. There is a great need to address both the domestic division of labour, corporate responsibility, and public policy. As long as women maintain their roles as caregivers to elderly kin, there appears to be little momentum for rethinking the crucial issue of caregiving, until at least, women caregivers unite to bring awareness to the issues affecting them and their loved ones. Neena Chappell (2009) concludes the role of caregivers, asserting that many older adults do not work for pay. Their work is not socially sanctioned or even valued. Having fewer children and more daughters working increases the responsibilities thrust upon ageing spouses (Chappell, 2009).

Economics, Divorce, and Separation for Women in Old Age

McDonald and Robb (2004) write of older women's "legacy" of poverty as a result of widowhood, divorce, and separation as having an impact on the availability of resources (i.e.

long-term care) in their later years (p. 84). They assert that although gains have been made for older women in Canada over the last twenty-years, the weight of a low income in old age is still carried by unattached women. The category of *unattached* encompasses the separated, divorced, widowed, and “ever single”, all of whom confront varied circumstances in old age due to differences over the life course (p. 83). For example, 21.1% of unattached older women in Canada live in poverty. When income before taxes is considered, a disturbing 47.9% of unattached older women are impoverished. In terms of widowhood, one in four Canadian women will be widowed, accounting for 45% of all women aged 65 and over (Statistics Canada, 2001). Moreover, 13% of Canada’s population (4.03 million) are over the age of 65. According to Statistics Canada (2001), the impact of widowhood is immediate.

When considering the dynamics of predicting the income of married women in later life, it is family-not personal income, that is related to higher levels of financial security. Should marital support dissolve through the death of a husband, women’s “secondary poverty” becomes all too clear (McDonald & Robb, p. 84). For instance, an examination of household income for the retired showed that separated and divorced women had the lowest yearly retirement incomes, second to widows. It must also be recognized that many of these women took time off from their careers to tend to child-rearing responsibilities, a sacrifice which is not protected by the Divorce Act. This information revealed that the separated and divorced are the poorest of all unattached women in Canada. A primary source of the difference is the disparity in growth in private pension incomes (McDonald & Robb, 2004).

Long-Term Care, Social Class: A Women’s Issue

According to Browne (1986) social class includes the stratification of a population and refers to differences based upon income, wealth, occupation, status, power, group identification, and family background. In terms of looking at white Anglophone-Canadian-born working-class women, it is important to consider that many of these women came from a generation where it was rare for a woman to be employed and self-sufficient. Second, many of these women are used to being the caregiver, not the cared-for. The notion of being under the care of another can be very demeaning for a self-reliant woman used to caring for herself and others (Cancian & Olicker, 2000). For the aged client in a long-term care centre, there is a painful kind of humiliation that seems to stem from their vulnerability, which is exacerbated by their loss of both physical and psychological strength and balance (Browne, 1986).

Skinner (1992, p. 127) and Weinberg (2000, p. 566) write of long-term care being primarily a “woman’s issue”. Previously discussed, women are more likely to be both the providers and the recipients of long-term care. Further, because of differences in longevity, older women are much more likely to be widowed than older men and are, therefore, at a greater risk of institutionalization (Skinner, 1992). In Ontario there are over 75,000 nursing home beds. More than 75% of these beds (approximately 56,250) are occupied by women, many of whom have a moderately severe dementing illness (CWHN, 2010).

Women’s Satisfaction in Eldercare

In terms of women’s satisfaction in eldercare, the literature tended to focus on older peoples’ mental health in general, and did not necessarily focus on women’s mental, emotional, and spiritual well-being in particular. For instance, according to Wasylcnsky, Martin, Clark, Lennox, Perry, and Harrison (1999), the later years lead to significant changes, stresses, and challenges which jeopardize the individual’s self-esteem and personal

coping. However, the elderly tend to define their life events as being less stressful than do younger adults (Wasylensky et al., 1999). Older persons have a distinctive set of psychodynamic responses to stress, regardless of its biological or psychological nature (Solomon & Zinke, 1991). Loss is a significant factor affecting elderly persons in general; however, losses involving family and friends are most deeply felt by women (Gatz, 1995). Freed (1987) notes that elderly women take their role as caregiver sincerely and struggle to deal with the tension and conflict that arise in assuming such a crucial role. While this information does not necessarily pertain to women residing in long-term care facilities, if they had acted as primary caregiver to their spouse, who later died (which studies proved they probably have), this may inadvertently affect their overall current satisfaction level in their long-term care centre. Moreover, issues of loss and the psychosocial issues that accompany this inevitability could actually result in mental health diagnoses (Rogers, 1999). These issues are exacerbated by demographic variables such as female gender, low education level, being 70 years old or older, loss of financial resources, and loss of social support network (Rogers, 1999).

Women and Health

Illnesses exclusive to women must be considered in examining elderly women and their use of long-term care facilities. Certain health problems are faced by both men and women, and in similar proportions, others are limited to women. Others are age-related and are more likely to occur among women (Ford, 2010). The leading cause of death for Canadian women is cancer. In fact, one in nine women in Canada will develop breast cancer in her lifetime. In 2003, 21,100 Canadian women will develop the disease, and about 5,300

will die from it (Ford, 2010). Women between the ages of 40 and 69 more often die from cancer, whereas women over 80 years of age more frequently die from heart disease (Ford, 2010). Currently, more Canadian women die from lung cancer than breast cancer every year due to an increase in cigarette smoking as well as the large numbers of ageing "baby-boomers" that are dying from smoking-related causes, reflecting the growth and age of the Canadian population as well as past smoking behaviour (Health Canada, 1999).

For women over 65, heart disease is the leading cause of death. Very old (85 and over) white women are at an even greater risk of dying from heart disease. Although women tend to have half the coronary heart conditions of men, women who suffer heart attacks are more likely to die from them than men in practically every age group (Ford, 2010). In terms of disability and illness, women are more likely than men to suffer from Alzheimers, osteoporosis, chronic diseases, falls, vision impairments and experience more hospitalizations (Health Canada, 1999). As previously discussed, they are also, on average, poorer than men and more vulnerable to inadequate nutrition and to difficulty in accessing uninsured healthcare such as medications. Osteoporosis is a condition that affects men and women drastically. In fact, osteoporosis is the leading cause of hospitalization among older women. Further, the frail elderly, especially those with low incomes and lack of informal support, may continue to reside at home without adequate care until their condition reaches severity and they eventually become hospitalized (Cohen, Tate & Baumbusch, 2009). These issues alone make elderly women more likely to be residents of long-term care facilities, and thus, their satisfaction in such institutions of critical importance.

Aronson (2002) published a noteworthy Canadian study concerning elderly people's "missing voices in long-term care policy debates" (p. 399). At the centre of these missing

voices are the voices of women. In recent years political and ideological shifts have resulted in a continual cutting-back in public provision of community and social care (Aronson, 2002). These cut-backs in the quality of publicly-funded eldercare have had negative consequences on seniors' life satisfaction, with an even more devastating effect on senior women, being as they are the majority of long-term care recipients. Aronson (2002) attributes this shift in political ideology to the "individualism characteristic of modern societies", meaning that "dependence" is criticized as being a flaw in character, rather than as a flaw in the social system in which we live (p. 400). This concept of blemished character is reminiscent of the long-standing phase of victim-blaming, wherein the most vulnerable populations (e.g. minorities, women, the elderly, and the disabled and impoverished persons) are trapped in cycle of oppression (Bishop, 1994). What may be most important from Aronson's (2002) study is that the women she interviewed recognized they were in vulnerable "power-over" positions simply because of their age and gender, and felt silenced as a result of these facts (Bishop, 1994, p. 30). A 70-year old female participant in Aronson's (2002) study spoke of the social origins of her vulnerability: "...they choose disabled and elderly because they don't have a strong voice and if they're going to cut money that's the way to do it" (Aronson, 2002, p. 415).

In a vein similar to Aronson's (2002) discussion above, Ball (1992) encouraged Canadians a decade earlier to lobby for maintaining the "excellence that has become our healthcare system" (p. 132). The author suggests doubling our taxation rates, have everyone work an extra two days per week to increase productivity as a nation, or a complete restructuring of our existing systems to make them more efficient and cost-effective (Ball, 1992). Although these suggestions may better long-term care as a whole, doubling taxes and

increasing days worked is not conducive to elderly working-class women who are already struggling to meet their future and/or existing long-term care needs. Nevertheless, service providers and consumers have common objectives: both want a high-quality yet affordable system of care for the elderly. Ball (1992) argues that the first step to achieving this system of quality eldercare lies with healthcare professionals. The author asserts that healthcare professionals are at an advantage because by working together they can create a system of care that is coordinated, cost-efficient, and effective. Together, they can take the lead role in creating a new system. This is critical in working with white Anglophone-Canadian-born working-class women, who by nature of their longevity make them more vulnerable to chronic and debilitating illnesses and poverty. Healthcare professionals (social workers in particular) can join together to ensure that externally imposed reforms do not wash over them or their clients (Ball, 1992).

Elderly Women and Self-Identity

Unlike older data, which implied that age has little impact on self-esteem or that self-esteem actually increases with age, McMullin and Cairney (2004) discovered that levels of self-esteem lower as we age for both men and women. Moreover, women have lower levels of self-esteem than men in general. Social class does not appear to affect levels of self-esteem for Canadian men or women, but does for those in middle age and older age groups (McMullin & Cairney, 2004). The social worlds in which older women pursue their daily routines, however, are filled with uncertainty perhaps because of their close proximity to death. These factors combined with the plethora of concerns already plaguing white Anglophone-Canadian-born working-class women, and self-identity becomes a significant

factor in the discussion of age-stigmatization (i.e. ageism). The Government of Canada deems a citizen to be senior at age 65. Perhaps the state carries the most weight in defining what is considered old and therefore changes in perceptions of elderly women should begin here. Moreover, in the discussion of white Anglophone-Canadian-born working-class women, they are by virtue of their gender, age, and socioeconomic status, subject to various forms of oppression, which inevitably affect their self-identity and thus their satisfaction with life in their later years (Bishop, 1994).

Neysmith and Macadam (1999) consider the disregarded reality that women experience old age differently than men do. One of these differences is that white North American women exist in an ageing body amongst a culture where the ideal body is young, strong, thin, able, and male (Neysmith & Macadam, 1999). To be old, overweight, disabled, or female is to be inferior. Although much has been written about the condition of the ageing female body, the negative implications societal influences has on the well-being of old women has been ignored. What tends to be the focal point throughout the literature pertaining to elderly women and their bodies are the effects of one's frailty on their ability to perform certain tasks related to the activities of daily living (Neysmith & Macadam, 1999). The authors note that old age and the images that accompany it are socially constructed. Frailty, physical deterioration, and the universal, degenerated body that the elderly live in are a product of society's belief that old age equals dependency, incompetence, and disability. This belief system exacerbates the situation for white Anglophone-Canadian-born working-class women whose sense of security and quality of life is already in jeopardy as a result of their vulnerability to illness, poverty, stigmatization, and oppression, simply by virtue of their longevity.

Neysmith and Macadam (1999) stress, however, that although too much emphasis on social construction can result in policies that minimize how not having certain capabilities affects one's life, it is these policies that determine one's functional abilities, thus establishing eligibility for services. The major challenges to the dominant images of dis/ability (sic) and the social construction of dependency related to such images have come from the disability movement (Neysmith & Macadam, 1999). The activists of this movement were primarily young persons with disabilities who were concerned with issues of independent living. Elderly women and their body image and capabilities were not a main concern. Although we are beginning to see a much needed increase in attention being afforded to elderly women and self-concept, the presence of an aged body serves as a constant reminder of what the future holds if one lives to an old age. This inevitability is worsened for women who are continuously bombarded by images and advertisements to stay thin, to stay healthy, and most importantly to stay young (Neysmith & Macadam, 1999). Old age is an inescapable fact of life and something that should be embraced, rather than dreaded. However, for many North American elderly women their age is accompanied by shame, which affects their overall quality of life (Neysmith & Macadam, 1999).

Feminist Frameworks and Social Work practice

Feminism and social work share similar principles. These include appreciation of the inherent value and worth of every person, the right of all human beings to reach their full potential and the prevention of discrimination and oppression in society (Wetzel, 1986). These commonalities between feminist ideology and social work practice itself assert that every individual can be best understood by exploring them in their natural environment.

Therefore service should concentrate on generating relationships between individuals and their environments, which will enhance the intrinsic dignity and worth of every person (Wetzel, 1986). Feminism and social work are both dedicated to the belief that all people are capable of change through exploration of their transactions with their social environments (Wetzel, 1986; Collins, 1986, VanDanBerg, 1995). Various frameworks for feminist social work practice have been produced (Baines, 1989). Many of these frameworks encompass theories of human behaviour as well as feminist values, goals, and philosophies (Bricker-Jenkins, 2002).

Some feminist scholars argue that feminist ideology, ethical standards, and practices are equal to that of the social work profession (Sandell, 1993). Baines (1997) argues that notions of equalizing the power balance in interventions with clients is at the heart of feminist social work theory and practice and must consider the ways in which race, class and gender affect the helping process, especially in institutional settings, such as hospitals and long-term care facilities. Perhaps the notion of intersectionality may be useful in addressing the socioeconomic, racial, and gender inequalities that affect feminist social work practice (McCall, 2005). Intersectionality is a theory suggesting that diverse socially and culturally constructed characteristics of discrimination interact on numerous levels, contributing to social inequality (McCall, 2005). Intersectionality asserts that oppression based on race, gender, class, religion and disability do not operate as separate entities, but are interrelated, thus forming an intersection for multiple forms of discrimination within society (McCall, 2005). Perhaps adapting an intersectional approach within a feminist framework for social work practice would be useful in understanding oppression and discrimination (Ontario Human Rights Commission, 2001).

Chapter Four: Social Work Practice and the Elderly: Roles and Responsibilities

In Canada, social workers employed in long-term care centres are part of an interdisciplinary team that addresses residents' physical, medical, psychological, and social needs (Holosko & Feit, 2004). Much of the social worker's time is spent working directly with residents and their families. The social worker is involved in making assessments, counselling, performing psychosocial evaluations and formulating care plans (Holosko & Feit, 2004). These crucial duties are undertaken by the social worker at Extendicare Bayview. In smaller long-term care facilities that do not employ a director of admissions, the social worker will often assume the responsibility of admitting persons and smoothing the progress of their transition to the facility. However, admitting residents is not a function performed by the social worker was at Extendicare Bayview, even though they do not employ a director of admissions (Holosko & Feit, 2004).

In most facilities across Ontario, social workers also help facilitate admission procedures by presenting the centre to the resident and their family, and introducing the resident to staff and other residents. This introductory process is referred to as a "tour" and is a further task performed by the social worker at Extendicare Bayview. Another crucial role of the social worker employed in a long-term care facility is to address the psychosocial issues of the residents (Holosko & Feit, 2004). For instance, if a resident is confused and cannot find her room, or is lonely and expressing suicidal thoughts, or if she isolates herself in her room, in most long-term care facilities it is the responsibility of the social worker to address these problems, as they are at Extendicare Bayview (Holosko & Feit, 2004). This involves conducting a psychosocial assessment of the resident to evaluate such things as the

resident's orientation, memory, attention, self-image, sociability, initiative, and relationship with family, staff and others (Kelchner, 2001). Issues in these areas can be addressed by working with the residents individually or in groups. Common types of groups social workers in long-term care centres facilitate include reality orientation, validation therapy, reminiscence groups, and socialization groups, however, these types of groups were not functions at Extendicare Bayview, with the exception of socialization programs, undertaken by the recreation staff (Holosko & Feit, 2004).

Another important social work function in long-term care settings is providing information and referral services. Particularly, the social worker informs residents and their families of certain services for which they may be eligible and connects them to such services. For instance, if they desire spiritual guidance, the social worker will arrange visits by a minister, priest, or rabbi; or if a resident needs new eye glasses, hearing aid, or dental work, the social worker can arrange for these services, provided that their client has the finances to pay. The social worker plays a very operational role in providing information and referral services to long-term care residents because these residents are dependent and require help in obtaining needed services (Holosko & Feit, 2004). Thus, in addition to providing information to residents and their families, the social worker also has to make appointments, arrange transportation, and sometimes even personally accompany a resident to an appointment. Further, social workers may also become involved in resident conflict resolution. When residents have a conflict between one another, the social worker has the task of trying to resolve the situation (Holosko & Feit, 2004).

In terms of practice approaches undertaken in long-term care settings, Richardson and Barusch (2006) note that demographic changes have significant implications for gerontological social workers, in that the data indicates a need for a practice model of ageing that includes a “multidisciplinary life course perspective and recognizes the importance of heterogeneity, diversity, and inequality” (p. 12). An integrative method is particularly effective with elderly clients, who typically present issues involving biological, psychological, and social factors (Richardson & Barusch, 2006). Kelchner (2001) also speaks of facilitating an empowerment approach in work with older adults, especially for those in long-term care centres, who may feel they have lost their sense of independence. An empowerment approach includes a sense of control and quality of life, opportunities for choice, personal decision making, and the presence of support systems (Kelchner, 2001). Some methods that have been used in an empowerment approach with older adults include story sharing, community work, one on one, and group-oriented empowerment strategies (Kelchner, 2001). Group work employs group work methods to empower older adults to join in their community. Community work seeks to empower older adults through direct participation in one’s community, including the long-term care nursing home community and assisted living community (Kelchner, 2001). It is important to note that institutional settings may present unique challenges to older adults living in residential settings, as they may fear retaliation if they “complain” about conditions or treatment (Kelchner, 2001, p. 120).

Chapter Five: Practicum Research Plan: Significance of Research Project

As noted throughout, there are very few studies that have explored white Anglophone-Canadian-born working-class women in eldercare. Clearly, this would indicate a serious gap in knowledge pertaining to this particular racial/socioeconomic group. It is well-known that women tend to be both the providers and recipients of care (Skinner, 1992). It is also recognized that women typically live longer than men and are financially more vulnerable (Hankivsky et al., 2004). They will more likely become widows, as one in four women will be widowed, accounting for 45% of all women aged 65 and over (Statistics Canada, 2001). It has been established that many elderly couples spend their savings to care for the older male spouse, leaving little left for the provision of care for the female spouse (Hankivsky et al., 2004). The situation is more dismal for working-class elderly women, as every dollar they earn goes to their daily living expenses, and not necessarily put aside in a savings plan for the provision of their long-term care needs (Hankivsky et al., 2004). There are also mental, emotional, social, and spiritual problems that affect women's well-being in particular. This data appears to reflect a relatively low life satisfaction among elderly women in general. It is my intention to identify the factors that contribute to women's positive experiences in eldercare and to explore what features may enhance the not-so-positive experiences of white Anglophone-Canadian-born working-class women in eldercare.

This specific ethno-cultural/social-class group was chosen because sufficient literature has not been written about this population, but has tended to focus on various other ethnicities' experiences in long-term care settings. Most of the literature has been from a white male-American perspective, concentrating on working-class minority groups, such as

Hispanics, and African-Americans, whilst primarily emphasizing a need for Social Security reform. Working-class white women in Canada are a vulnerable population as well. Many, if not most, have experienced a series of losses, including the loss of a spouse, a friend, and employment (Beaver & Miller, 1992). Further, many of these working-class white women may feel as though their experience in eldercare could be more positive if they had sufficient financial support. As noted earlier, a report published by the Canadian Association of Social Workers (CASW, 2007), revealed that women are currently experiencing exceptional financial disadvantages. The income rate among senior women was twice as low as it was for men in 2006 (CASW, 2007), with more than 20% of single senior women living on a low income. As a consequence of the issues discussed above (gaps in research, longevity factors, mental, emotional, social, and spiritual well-being, issues associated with loss, and financial vulnerability), the research component of my practicum will explore what specific attributes are associated with a positive experience for white Anglophone Canadian-born working-class women residing in long-term care in Ontario and what some of the challenges of adapting to this stage of transition may be.

Chapter Six: Methodology

Qualitative Research

Given that this report was constructed based on my own experiences as a white Anglophone-Canadian-born woman from a working-class background, I was influenced by auto-ethnography, a qualitative research method. Qualitative research is a system of data collection and analysis that is used to gain insight into people's behaviours, attitudes, value systems, concepts of the world around them, motivations, aspirations, culture or lifestyles (Patton, 2002). It is concerned with why phenomena occur, not necessarily how it occurs. Qualitative findings stem from different types of data collection, mainly interviews, direct observation, and written documents (Patton, 2002). Typically, data collection and analysis is obtained through fieldwork. It is through fieldwork that the researcher is situated in the environment under study and collects their information through observations, interviews, and document analysis (Patton, 2002). Since I undertook a practicum, I was able to conduct fieldwork at Extendicare Bayview, collecting data through interviews.

Auto-ethnography

Auto-ethnography is a qualitative research method, wherein, the researcher uses their own experiences to harvest insights into the culture and/or subculture of which he/she is a part (Patton, 2002). Vast variation exists in the degree to which researchers utilizing auto-ethnography make themselves the concentration of the study, the extent to which they use the sensitizing concept of culture in guiding their analysis, and how personal their writing is (Patton, 2002). What is at the centre for auto-ethnographers is explicit self-awareness about reporting one's own experiences and introspections as a principal data source (Patton, 2002).

Narratives are created based on the writer's personal experiences within a culture, creating an autobiographical mode of writing and research, presenting compound layers of consciousness, connecting the personal to the cultural (Patton, 2002). Charmaz (2006) suggests a researcher begin their study by examining the actions of the actors, and by answering the following questions: what is the setting of the action? When and how does action take place? What is going on? What is the overall activity being studied, the long-term behaviour about which participants organize themselves? What specific acts comprise this activity? What is the distribution of participants over space and time in these locales? (Charmaz, 2006). It should be noted, however, that due to the relatively narrow scope of the research component of my practicum, all of these questions may not be applicable to my practicum report and therefore will not be included.

Auto-ethnography and Reflexive Observations

Auto-ethnography is also referred to as reflexive observations. In using reflexive observations the researcher is not necessarily part of the group/population being observed and involves the following types of questions: basic descriptive questions (for example, can you tell me about your chemotherapy? Tell me what happened on that evening? Describe how you felt that afternoon?), follow-up questions, experience/example questions, and simple clarification questions (Patton, 2002). The researcher's knowledge is gained by observing what is occurring around them and by making note of what is transpiring in that particular setting. It is a form of autobiographical personal narrative that looks at the writer's understanding of life. An example of reflexive observation/auto-ethnography includes statements such as "in my role as a student I noticed...." and "it was difficult asking that

question because....” Reflexive observation involves observing people in their natural environment (field), and is the only method which gives empathic understanding of subjective experiences (Patton, 2002). During our conversations, I made note of the participants’ thoughts, views, and opinions, as well as some general observations, and inserted them into my practicum report. I provided feedback to my participants throughout this process by reading back our interviews verbatim, ensuring they were not misquoted and that I was accurately documenting their articulated experiences. As stated in my Information Sheet (Appendix A) that was provided to my participants, it was also at this time that I provided an opportunity for the participants to remove any parts. None of them did.

Analysis

In terms of how I analyzed my findings, I used a thematic analytic approach. A thematic analysis is a widely used method of examining data in qualitative research that focuses on particular themes and patterns of experiences and/or behaviours (Aronson, 1994). This form of analysis is highly inductive, that is, the themes materialize from the data and are not imposed upon it by the researcher (Boyatzis, 1998). Simultaneously, the data collection and analysis take place. Background reading can sometimes form part of the analysis process, particularly if it can help explain an emerging theme (Boyatzis, 1998). Documented interviews are collected to study the conversations of an interview. From the conversations, patterns of experiences can be listed (Aronson, 1994). This can come from direct quotes or paraphrasing common ideas. I chose to use the participants’ actual quotes in an effort to maximize their voices.

Based on my participants' answers to my queries, I searched for common responses. I was then able to list the commonalities (themes), ultimately arising at a series of conclusions, which are discussed in Chapter Ten.

Chapter Seven: Participants and Ethical Issues

As previously mentioned, 3 white Anglophone-Canadian-born working-class women residing at Extendicare Bayview were selected from a pool of Marcy Turkel's (practicum supervisor) clientele and asked if they would like to participate in my research. These 3 women were lucid and asked to sign informed consent (Appendix B) about their voluntary participation in this project. It was explained in writing (Appendix A) that they could withdraw participation in the study at any time without consequence, and any information they had shared to that point would not be included in my practicum report. These interviews were conducted in the privacy of the residents' rooms and in all three cases were completed on the same day the interviews were initiated.

Ethical Issues/Considerations

I have also completed the Interagency Advisory Panel on Research Ethics' Introductory Tutorial for the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS), which prepared me for ethical conduct involving human subjects. The practicum proposal and specifically the research component was reviewed by the Research Ethics Board at the University Of Northern British Columbia (UNBC) and will be available at the UNBC library upon publication. Further, I will provide Extendicare Bayview with a copy of my report, which will be accessible to my research participants. I personally made my participants aware of the accessibility of my report.

Semi-structured Questions for Participants

Each of the three participants were asked the same set of six interview questions in a semi-structured interview approach. A semi-structured interview approach is a method of conducting an interview that is flexible, allowing new questions to arise during the interview, usually as a consequence of what the interviewee says (Patton, 2002). The interviewer in a semi-structured interview typically operates within a framework of exploring themes, leading to the thematic analysis which was undertaken in examining my data (Patton, 2002). I chose the semi-structured interview approach because I believe it allowed a greater opportunity for my participants to express themselves fully. The questions asked are listed below.

Questions

1. What has been helpful/ supportive of your well-being at Extendicare Bayview?
2. What has sometimes hindered your well-being at this residence, specifically?
3. What are some of the challenges of adapting to life in a long-term care setting, generally?
4. In what ways do you feel different about yourself, as a white Anglophone-Canadian-born woman, since you have been residing here?
5. In what ways are these feelings specific to you because you are a white Anglophone-Canadian-born woman?
6. Where else in your life have you learned skills that have proved useful here?

Chapter Eight: Limitations of the Research Design

One of the limitations of the research design was the small number of participants involved (3). While using such a small sample may allow for a more thorough exploration into the experiences of white Anglophone-Canadian-born working-class women in eldercare, it may have limited the variety and extent of other women's experiences in long-term care (women from other ethno-cultural/socioeconomic backgrounds, for example). An additional limitation may have been the relatively short period of time that was spent with the participants. Although the duration of this practicum was 560 hours, it did not qualify as a longitudinal study, which may have limited the opportunity for the formation of a therapeutic alliance. However, the restricted time period may have been beneficial in avoiding issues of transference/countertransference (Levine, 1996). Transference is the unconscious projection of feelings from one person onto another. These feelings can range from an attraction towards a therapist, to other forms such as rage, hatred, mistrust, and even extreme dependence (Levine, 1996). Countertransference, however, occurs when the therapist unconsciously redirects feelings toward a patient, or more commonly as a therapist's emotional entanglement with a client (Levine, 1996).

A further limitation includes the fact that these women may not have been completely forthcoming in their responses to my queries about their experiences at Extendicare Bayview because they may not want to "complain" about their conditions or treatment in an institutional setting (Kelchner, 2001, p. 120). Another limitation may have been the fact that I am a social worker and master's student and, therefore, may not have been regarded as a member of the same group. Although I identify as a working-class woman, I may not have been perceived as such because I am coming from a position of

power (Saleeby, 1992). A further limitation was that the participants were speaking about their experiences at Extendicare Bayview, which may not be reflective of other women's experiences in long-term care as a whole. Moreover, these experiences may not be transferrable between the provinces. Lastly, other issues which may have arose in this research design include transference and/or countertransference resulting from the age difference between the student/researcher and the participants, which may have affected the participants' behaviours and responses to interview questions (Levine, 1996).

Chapter Nine: Interviews

The following section is the complete interviews conducted with each participant. I decided to include the entire conversations with my participants to make for a more detailed explanation of their experiences, while allowing them to have their thoughts, feelings, and views fully expressed and documented. This may allow for a more thorough understanding of their experiences, while ensuring that their words are not misinterpreted (Duncan, 2004). For the purposes of this report, the three women interviewed were assigned aliases: “Estelle”, “Annette”, and “Mavis”. Other pertinent information (for example, their exact place of birth) were not included to protect their identity. These interviews were conducted at Extendicare Bayview in August 2008.

Estelle

Estelle was born in Ontario. She has been a resident of Extendicare Bayview for seven years. She is a jovial woman who admittedly tries to “look on the bright side of things”. She is confident and possesses a dry, sarcastic sense of humour, which she asserts comes from an understanding that “everyone in life has problems and deals with these problems in their own ways at their own time”. Her parents were Eastern European immigrants. She is one of three children. Estelle was employed as a bookkeeper, stating “numbers are my thing”. She excelled at folk dancing, contending that this was her vocation. Estelle never married, nor had any children.

Question One: What has been helpful/ supportive of your well-being at Extendicare Bayview?

“The management and staff have been helpful and supportive because if something is wrong, they fix it ASAP”. (Maintenance was in the room fixing the call bell at the time).

“What happens with residents here, because of their illnesses, is that people will change from second to second. You have to expect anything. This home has so many programs that others homes don’t have. Resident’s don’t have to pay for any of these programs; all the supplies, etc. are paid for. This home works hand-and-hand, glove-and-hand. The management and staff work very well together. There are times though when my patience gets worn very thin. People come in with different problems, some will have dementia and some will not. This sometime makes it difficult for me. I am a welfare person so I couldn’t get the job done in time. I mean I couldn’t get to another home. The staff here is always helpful, they are really important and will always help immediately. I don’t know how other homes are, I only know this one. Bayview even has outings where we go to Centre Island. These programs and institutions are to make our quality of life better and they do. People in long-term care in general should be happy and contented”.

Question Two: What has sometimes hindered your well-being at this residence, specifically?

“Well, sometimes what has not been too helpful is that the staff is cranky. I have been yelled at by a staff member and have yelled at staff too. That’s life. People have good days and bad days. Sometimes you speak to people in a way you wish you had not, but it happens because we are all human and will have good days and bad days. There are times when people will fight and argue and disagree, but not all residents see this as a normal part of life and sometimes a fight will happen over a silly thing. Sometimes people will have something that bothers them and will keep it to themselves. Something else will happen and it will set

them off. Another thing that happens in long-term care is the lack of privacy because residents do not have any privacy. Doors do not have locks and belongings are not locked either. Security is only in the offices. Extendicare Bayview is not a prison-it is a place where people must get used to being away from what they are used to and sacrifice their independence for care.”

Question Three: What are some of the challenges of adapting to life in a long-term care setting, generally?

“Coming into a long-term care home is challenging because everyone has a disability of varying degrees. When coming into a long-term care home one has to realize that things as they know it will be different. For example, you have to share everything, give up your privacy, give up your independence, and learn to get along with people from all walks of life. One has to remember that they are giving up one life for a new life. I would say that I gave up a single life for a communal life. It’s hard to get used to eating and sleeping, and eating and sleeping, day after day. You even have to talk to people when sometimes you don’t feel like it. It’s also challenging because activities are geared for everyone, and not everyone wants to do the same things. Also, if you want to go somewhere you have to arrange to have someone go with you. It’s always challenging when everybody and their brother walks into your room-everybody’s room is fair game. All long-term care homes are like this, not just Extendicare Bayview. Life is comical if you let it be, so don’t sweat the small stuff (smiles). It’s a positive attitude that makes this place liveable”.

Question Four: In what ways do you feel different about yourself, as a white Anglophone-Canadian-born woman, since you have been residing here?

“Well, because I’m only 67 years old, I’m much younger than a portion of the people here. And the fact that I have all my druthers in my skull, I sometimes forget that other people do not. I’m also really looking forward to taking the position of Ombudsperson with some trepidation because it’s new to me. In terms of being a white Anglophone-Canadian-born woman, this has had no effect on my self-conscience because we are all people with the same problems. Each person has to grapple with a different point of view. I deal with my problems in my own way because I feel I was blessed by God with a brain that thinks and reasons, which has taken some time to be realized from my immature body-I used to be a kid! It was only recently that I began to realize that I was blessed with a brain that functions and I should take advantage of that. I have also come to realize that many of the things that bothered me are so trivial they don’t rate thought.

Question Five: In what ways are these feelings specific to you because you are a white Anglophone-Canadian-born woman?

“As I have aged I have slowly become more philosophical. I do not consciously think of myself as a white Anglophone-Canadian-born working-class woman. I simply think of myself as being a mere speck in the grand picture of existence. I do not think that my views of myself in long-term care have anything to do with being white or being a woman or being working-class. I’m just a person”.

Question Six: Where else in your life have you learned skills that have proved useful here?

“I guess I learned things that have proved useful here just by being the person I am. In grade school I went to school like everybody else did. I was also a folk dancer and a camp counsellor. I took up folk dancing because I did not need a partner to folk dance-a woman or

a man can be a folk dancer. I also liked the opposite sex, but I am not a fool, you do not need a man partner to dance. In my work, I was a bookkeeper, and that made it easier to keep the books for the folk dancing group. Being a folk dancer has helped me at Extendicare, Bayview because I can relate to people and talk to people on a one-to-one basis, as well as in groups. The opportunity of being an Ombudsperson for Extendicare, Bayview I think, opens doors and windows to use my skills in 67 years of living. Something I have learned living here at Extendicare Bayview is that one must take things one day at a time. In folk dancing, I was also a program director. I had to organize many shows. They are all over Canada now, and America too. Folk dancing allowed me to experience different foods, cultures, customs, music, and stories (through story telling). I learned a lot about other people through my folk dancing. Learning about other people from all walks of life, regardless of their vocation or avocation. These skills have been useful for living in long-term care, but have also helped me grow as a person and deal with others.

Annette

Annette was born to English-speaking parents in Québec. An only child, her father was a salesman and her mother was a dressmaker. When Annette was twenty-five, she married and had a daughter. Her husband left her, leaving her to raise her daughter as a single mother. She worked in the accounting department for an insurance company doing odd jobs. She arrived at Extendicare Bayview in early 2008 after she had a fall in her apartment.

Question one: What has been helpful/ supportive of your well-being at Extendicare Bayview?

“I guess not having to make my own meals. It’s nice to have someone get me ready for bed. With this Parkinson’s disease I have, it’s nice to have people care for you. Some care more than others. They should all be praised for the work they do, but for some people it’s just a job. You see, I was in a shared room before this one. The first room was in a different wing. We have three wings here. There are a great number of Alzheimer’s people in this building and they need more help than I do. Then there are folks like me who need a little less care than the Alzheimer’s folks. Where I was before (in the other wing), people needed less care and it was much more fun. The girls (staff) were more pleasant. I’m not saying I’ll be normal forever, but it’s Parkinson’s Disease that gives me the hard time, not Alzheimer’s.”

Question Two: What has sometimes hindered your well-being at this residence, specifically?

“Well, I don’t really care for the showers. You see, they have to shower people who can’t do it for themselves. The showers aren’t like how they are at home. At home you can eat your breakfast and take a shower whenever you feel like it and not really think much about it. You see, when at home you showered whenever you wanted, but now you have to be showered twice a week. This is set by the Ministry (of Health and Long-term Care). Another thing that gets to me sometimes is the service in the dining room. They start to clear the table while you’re still eating. They also reach in front of you. This could be done when you have left the table. I know it’s not easy to please everyone, especially with the food. Not everyone will like the same food. I like the food. I think it’s very good.”

Question Three: What are some of the challenges of adapting to life in a long-term care setting, generally?

“It’s challenging when your peers die and leave you. It’s also hard when you don’t get to see your family as much as you would like. You also don’t want to feel like a burden to the people who look after you. It’s not easy to accept that you can no longer do the things that you were accustomed to.”

Question Four: In what ways do you feel different about yourself, as a white Anglophone-Canadian-born woman, since you have been residing here?

“I don’t feel different. I’m aware of all the people from different countries, but that’s about it. I’ve noticed that most of the caregivers are from another country, but this has had no affect on how I view myself as a white woman.”

Question Five: In what ways are these feelings specific to you because you are a white Anglophone-Canadian-born woman?

“Well, I guess because I am a white-Canadian-born woman I am more aware of people here (Extendicare Bayview) who are from other countries. It’s a very interesting question, but I guess I don’t really see myself as being that different.”

Question Six: Where else in your life have you learned skills that have proved useful here?

“I learned how to deal with other people by working for the insurance company I used to work at. There were many different people with many different personalities and I guess I learned a lot of things there. I’m also ninety-four years old you know so I’ve been around a long time.”

Mavis

Mavis is originally from Nova Scotia. Her father was a machinist and her mother was a “housewife”. Mavis is one of five children. She was married (her husband is deceased), had no children, and like Annette, worked in an accounting office for many years. She came to Extendicare Bayview in 2007.

Question One: What has been helpful/ supportive of your well-being at Extendicare Bayview?

“Well, I developed ulcers on my leg after I came here. They changed the dressings and gave me antibiotics. I’ve been going to the hospital for the ulcers on my legs about once a month. I was in another nursing home before this one, but this one is better because it only has one floor. My niece and nephew like it because it has no elevators and the cafeteria is on the same floor as my room. The home I was in before always had their elevators breaking down. I like to go to the activities too. The activities here are great, they really are. I like to go to mass too, which is the first Friday of every month. The priest is a very nice young man. Sometimes they bring communion in too”.

Question Two: What has sometimes hindered your well-being at this residence, specifically?

“In the beginning some of the nurses weren’t very nice. Sometimes they would act like they didn’t even see you. Also, I got ulcers on my legs when I got here. I also think that walking with a walker has made my posture worse. I seem to have gone backwards with my legs and my posture. I’m not as straight as I was when I got here”.

Question Three: What are some of the challenges of adapting to life in a long-term care setting, generally?

“Sometimes you miss being free to go where you want to go. Some people have to wear a bracelet that sounds an alarm when they try to leave the building. The meals are usually pretty good, but sometimes they serve things I don’t want. They serve a lot of pasta here, which I don’t really care for. Another thing is that sometimes your things will go missing. I had a plain gold chain go missing. Everybody knew, but what can you do? You can’t even keep money with you in your room because someone might take it. Sometimes things disappear. There’s not much privacy here and it can be hard to get to know people.”

Question Four: In what ways do you feel different about yourself, as a white Anglophone-Canadian-born woman, since you have been residing here?

“A lot of us here are white and there aren’t very many men, so I can’t really say I feel differently.”

Question Five: In what ways are these feelings specific to you because you are a white Anglophone-Canadian-born woman?

“Well, like I said, I don’t feel different, but there are many whites and many women so I’m not a minority. Colour doesn’t mean anything to me.”

Question Six: Where else in your life have you learned skills that have proved useful here?

“I don’t think I have a lot of skills, but in school you learn things. You also learn things working. You learn how to talk to people and new people come here I want to make them feel welcome. I don’t really have any great skills or anything like that. I try to go to a lot of activities to help keep my brain working.”

Chapter Ten: Discussion and Results

In terms of what has been supportive in the well-being of these three women, Estelle, Annette, and Mavis had similar perspectives. Both Estelle and Annette found the staff to be helpful in making their experience in long-term care a positive one, while Mavis appreciated that everything was on one floor, making it easier to access different areas of the building, which was important for her as she has limited mobility. Estelle noted that she enjoys the range of activities at no cost to her; Annette appreciated the prepared meals; and Mavis enjoyed being able to attend mass and receive communion. Activities appear to be an important component to the overall satisfaction with daily life in this long-term care facility.

Regarding what sometimes hinders the well-being of these women, both Estelle and Mavis found that the staff (although helpful) sometimes affected their satisfaction with the facility. Estelle described some of the staff as being “cranky” and Mavis found that some of the nursing staff “weren’t very nice”. Annette, as with the other women, found lack of privacy an issue, specifically noting that showering was an activity she did not look forward to.

Some of the challenges of adapting to life in a long-term care setting were also similar for each of the three women. Estelle described lack of privacy and independence as most challenging for her. Annette found that loss of peers and few family visits were issues affecting her adaptation to long-term care. She also noted that loss of independence was a difficult adjustment. As with Estelle, Mavis described lack of freedom and privacy as challenging issues for her to contend with. In terms of how these three women feel differently about themselves as white Anglophone-Canadian-born women, Estelle, Annette

and Mavis all felt that their ethnicity and gender had no effect. It should be noted that the majority of the residence at Extendicare Bayview are Caucasian women and therefore the participants may not feel differently about their experiences in long-term care because of this. Annette and Mavis felt that they learned skills that have proved useful in a long-term care setting through school and/or work. Estelle found that she developed skills through her folk dancing, which she noted helped her “relate” to people from varying cultures.

My findings were that overall, the experience of residing in long-term care in a privately-owned facility in Ontario is a positive one. A wide range of activities at no cost to residents (including religious services and monthly outings); quality prepared and served meals; an opportunity to utilize skills and talents; helpful staff; and a one-level building were important factors in my participants’ quality of life in long-term care. However, lack of privacy; loss of independence; loss of peers through death or relocation; and few family visits were not conducive to a positive experience in long-term care. These are common long-term care issues as women age and lose more of their independence and close social networks (Aronson, 2002). As previously discussed, ethnicity and gender had no effect to the participants’ overall well-being in long-term care.

Chapter Eleven: Reflections on the Practicum

In conversing with these 3 women, I felt they had adjusted well to life in long-term care. All three women felt that the abundance of activities played a role in their quality of life at Extendicare Bayview, however, there were things that they found bothersome, such as a lack of privacy and fear of their possessions disappearing (through theft). It was also felt that these women would like more time with family and friends, as they reminisced about their days at school and/or work. As Linda Tuhwai Smith (2006) discusses, every individual views their world based on their experiences. Everyone grows up with traditions and values which shape the stories they tell and their views of the world around them. Story-telling plays an important role in one's world view and these women's stories have indeed shaped who they are and how they perceive themselves in relation to life in long-term care. They each have personal histories and have gone through a series of losses, such as loss of their health, their independence, and loved ones. These are commonalities shared by many at Extendicare Bayview, which inextricably forms a bond amongst the residents.

I also noticed that there were groups formed, wherein certain residents tended to spend a great amount of time with the same people. Perhaps this was because they shared similar stories, having more in common with certain people. Although this may not be true for social workers in different practice settings, as a social work student coming into a closely knit community at Extendicare Bayview, the majority of residents were very welcoming and gracious to have a new face working with them. They asked many questions about me, as I did them. Working with this population provided immense insight into the hearts and minds of individuals residing in long-term care. Due to the aforementioned lack of

privacy experienced by the residents, I was conscious of some people's need for privacy. After getting to know the residents, I became aware of those who did not prefer intrusions into their room and/or life. Before entering a room it is customary to knock before attempting to enter. After being told several times not to enter, I understood which residents wanted to be left alone and I made an effort to respect their privacy. One resident in particular did not want any social service workers and/or nurses entering his room, and we were respectful of that, unless he needed medical attention.

As a white Anglophone-Canadian-born woman from a working-class background, I felt I was able to relate to residents of the same group, despite my age. I was raised by older parents and many of my living family members are themselves seniors. I was often told that I was respectful and polite and I got along well with the residents. I believe that this is because I come from a background that values old world traditions and customs. Moreover, many of the residents (not my participants) were Jewish, as am I. I had an understanding of their particular wants, needs, and values. This is not to suggest that I did not have an understanding of the wants and needs of residents from different faiths, but I believe that my being Jewish allowed a greater opportunity for residents of the same ethno-cultural background to open up and form a therapeutic alliance. Certain activities were geared toward celebration of Jewish holidays, such as Rosh Hashanah (Jewish New Year) and I took great pride in being able to assist the Jewish residents in preparation for this holiday. Although activities do not fall into the realm of social work responsibilities, the social worker is usually able to provide assistance when needed. I believe that my participation in activities provided an opportunity for residents to feel comfortable sharing their stories and allowed for the establishment of relationships, which may not have otherwise been achieved.

Roles and Responsibilities

Another task undertaken by the social worker (and myself) at Extendicare Bayview is conducting tours. For those wishing to have a loved one placed in a long-term care home, a tour is extremely important in attempting to convey what services are provided and how these services are extended. A tour takes approximately one hour and I conducted at least twenty. The tour begins by providing the potential client with a welcome package and discussing the facility's mission statement, payments, and services that are unique to the home. For example, Extendicare Bayview has a "Guardian Angel" program, wherein every resident is assigned someone to watch over them, ensuring that their transition into long-term care runs as smoothly as possible. If the new resident needs something to ease the transition, the "Guardian Angel" is there to help. Next, the potential client will be accompanied throughout the home being shown the different areas (such as the lounge) and will be shown the three types of rooms: private, semi-private, and basic. A private room consists of one bed and washroom where residents who can afford to live privately do so. A semi-private room has two beds and a washroom shared between the two residents. A basic room has two beds in each room, but what joins the four residents together is an adjoining washroom which all four residents can use. It should be noted that many of the residents are incontinent, so use of the washroom by four people is rare. Residents for each of the three types of rooms are encouraged to bring belongings from their home to make it more comfortable. Although other members of the management team are capable of conducting tours, the social worker does the majority of them.

Another duty that falls under the social worker's role is Team Care Conferences (TCC). Approximately six weeks after admission into the home, a TCC is arranged. The purpose of these meetings are to gather the team together (physician, nurse, dietary representative, social worker, recreation, physiotherapist, environmental manager) with the family and/or friends of the resident and often the resident themselves to discuss how they are doing, ensuring that they are satisfied with the level of care being received. After the initial meeting, the next TCC will take place annually, unless a special meeting is requested by the resident, family member, friend, or the home. It is the social worker's job to arrange for these meetings and she acts as the facilitator of these conferences. As co-facilitator of the Team Care Conferences, I was met with openness by the residents and their loved ones. Many were curious about me and asked questions about where I was from, what I was studying, why I chose long-term care and whether I was enjoying it. Several people were intrigued when I told them my school was in British Columbia and I was studying in Toronto. I felt I was able to establish a rapport with the residents and their loved ones during the Team Care Conferences.

As mentioned previously, in Ontario Community Care Access Centres (CCAC) are the initial points of contact for admission into long-term care facilities, as well as for coordinating home care services. The social worker at Extendicare Bayview works in partnership with CCAC to facilitate admissions into the home. CCAC maintains a waitlist for all homes and is responsible for making the bed offers to the potential client and/or family. A further task undertaken by the social worker that I assisted with was the completion of Occupancy Reports. Occupancy Reports are completed weekly to document how many residents are in private, semi-private, and basic rooms, keeping track of the different types of

accommodation. It also gives an account of what is happening in the home (number of admissions and discharges and reasons for the discharges), as well as the number of tours conducted throughout the home. This report also includes the successes and challenges that the home has faced throughout the week. This report is shared with Corporate.

My practicum experience at Extendicare Bayview was a very positive one. I interacted with many people from various cultures, races, religions, and classes, both inside and outside the facility (conducting tours, meeting residents' family and friends, other facility visits). Many were white Anglophone Canadian-born working-class women, many were not. The stories residents told me were both amusing and sometimes heartbreaking. Previously noted, story-telling sets the stage for how we view our reality. The women I interviewed shared memories which shaped who they are and how they perceive themselves, relative to life in long-term care. They each have histories defined by losses and gains. Many of the residents share a bond based on their commonalities and perhaps their differences. As a result of my experience at Extendicare Bayview, I too will have stories to share that may, in the future, help others understand their own ageing process.

Chapter Twelve: Objectives and Analysis

This chapter provides an overview of my specific practicum objectives. I examined each objective individually and discussed how each was achieved. Casual informal interviews, exploration of the socio-economic/political issues affecting the long-term care decision making process, friendly visiting/casual dialogue with residents, resident follow-up, visits of other long-term care homes within Toronto, and journal keeping (not included in this report) assisted me in achieving these goals.

Practicum Objectives/Discussion

1. To gain an in-depth understanding of the critical issues affecting white, Anglophone-Canadian-born working-class women in eldercare.

I conducted casual, informal interviews with residents of the above gender, class, and ethno-cultural background, so they could express their experiences in eldercare. I posed semi-structured questions for the women about their understanding of what (if anything) could make their experiences in long-term care more comfortable. I listened and observed the women at Extendicare, making note of their interactions with other residents, family members, and staff.

2. To achieve a greater understanding of the attributes that help women maintain a positive experience in a long-term care facility.

I examined and explored the women at Extendicare, again, making note of their interactions with other residents, family members, and staff. I also observed the female residents at Extendicare through direct interaction with them. I attended Team Care

Conferences (TCC) regularly to gain an interdisciplinary perspective of each resident's well-being in care.

3. To explore some of the challenges of adapting to life in a long-term care setting.

With their written consent, I performed informal interviews with three residents of the above gender, class, and ethno-cultural background, allowing an opportunity for the women to express their thoughts, feelings, and experiences about residing in eldercare. I also observed/explored some of the socio-economic/political issues affecting long-term care decision making processes, such as the effects community partnerships (e.g., Kosher Meals on Wheels) had on resident satisfaction. I also achieved this understanding through friendly visiting/casual dialogue with residents.

4. To explore some of the factors these women might like to change to make their experience in long-term care more satisfactory.

I worked closely with white Anglophone-Canadian-born working-class women on an individual and collective basis. I listened openly to learn as much as the residents were willing to share regarding their experiences and the meaning ascribed to them. I established a rapport and followed-up with residents I had engaged with for interviews to ensure I had accurately documented what was expressed in their interviews. I was assured I had.

5. To increase my awareness of the role of social work in the field of gerontology.

I read the agency social work employee manual as well as agency pamphlets and other pertinent information. I worked closely/observed my field instructor, eventually undertaking

her social work responsibilities (under her direct supervision). I had also arranged visits of other long-term care homes in Ontario (e.g. Baycrest, Carefree Lodge, Cheltenham Nursing Home, Cummer Lodge, Vallyview Residence, Kensington Gardens, Extendicare Lakeside) to enhance my understanding of the diverse role of social work within different long-term care settings.

6. To become familiar with the range of psychosocial issues affecting elderly residents in long-term care.

I worked closely with my field instructor and multidisciplinary team, asking questions when necessary, while also reading articles, books, etc. concerning ageing and mental health issues. Also, as previously noted, I attended and co-facilitated Team Care Conferences, conducted tours, and provided support to families, residents, and CCAC staff working with Extendicare Bayview.

7. To experience, learn, and compare my own experiences as a white Anglophone-Canadian-born woman from a working-class background, with that of women from the same racial/socioeconomic status, but from a different generation.

I accomplished this objective by sharing my own experiences and stories and contrasting them with that of the women I interviewed. I kept a journal of my thoughts, views, feelings, and opinions of my observations and interactions with residents, exploring feelings of uncertainty and discussed them with my field instructor when appropriate. I chose not to include these journal entries in my report as they are for my own personal insights and did not impact the formulation and/or end result of my report in any way.

8. To consider these challenges of transition within a feminist framework of social work practice.

I familiarized myself with a range of feminist scholars/writers and considered their perspectives within the challenges of transition to eldercare. This was briefly explored in my Literature Review.

9. To complete the literature review of long-term care centres and elderly women's experiences in such facilities.

I researched, read, and reviewed relevant scholarly journal articles and chapters from books, incorporating the articles and books into my practicum report.

10. To make recommendations for social work education, policy, practice, and research in the above noted area.

As noted throughout, I presented semi-structured questions for the women about their understanding of what (if anything) could make their experiences in long-term care more comfortable. I listened openly to learn as much as the residents were willing to share regarding their experiences and the meaning ascribed to them. I reviewed policy manuals and other pertinent information to familiarize myself with the Ministry of Health and Long-term Care's policies, mandates, and programs and how they interact with and affect social work practice in long-term care settings.

Chapter Thirteen: Implications for Social Work Practice

Social Work with the Elderly

There is little literature that pertains to working with seniors in Canada, especially when it comes to white Anglophone women from working-class backgrounds. This may be because social work practice with seniors is not glamorized as it may be for other sectors of practice. Although useful, much of the literature that does exist is primarily American. I recommend more attention be paid in the literature, especially to white Anglophone-Canadian-born working-class women who comprise an overwhelming majority of long-term care residents. Elder women's own narratives are especially important.

Practicum Experience and Social Work

Through my work with Extendicare Bayview I noticed that the majority of the residents were white females, each with unique needs. Social work practice should take notice of the fact that work with the elderly is inevitable, as our Canadian population continues to age. Presently, there is only one social worker at Extendicare Bayview, which may not be enough, as resident and family interactions are limited due to the large amount of administrative duties that takes away from client contact. This is not to say that there is no contact with the residents, however, it could be increased. I suggest that the current challenges facing our elderly population residing in long-term care homes have enhanced contact with social services in general.

Group Therapy and the Elderly

Further, Solomon & Zinke (1991) suggest that group therapy with the elderly does in fact assist with the overall well-being with nursing home residents who are suffering from depression and other mental and/or emotional ailments. Perhaps an increase in group therapy sessions with seniors would be beneficial in improving their overall well-being. Extendicare Bayview has an abundance of activities for their residents, but no group therapy sessions. However, the social worker does provide therapy on an on-going basis with residents and family members who are facing challenges in the facility. Perhaps increased engagement with individual residents would be helpful in making their stay more comfortable, both with the social worker and with outside agencies when necessary.

Accessing Care

In terms of accessing care, economic, geographic, and even cultural/language barriers are discussed as key issues affecting access to long-term care facilities (Hudson, 2002). Further, an ageing population, notable gaps in wages between men and women, and policy decision making continue to affect women's access to long-term care. Several studies have calculated calamity in the financing, organization, regulation, and delivery of long-term care. Due to the fact that women tend to live longer than men and are statistically more likely to be both the recipients and providers of services to the elderly, the barriers to accessing long-term care is a "women's issue" (Weinberg, 2000, p. 566). If access to long-term care is to be improved, public and private policy makers must unite to guarantee sufficient resources will be available to all, regardless of economic status.

How to Proceed

French philosopher and sociologist Michael Foucault had a particular interest in how alternative forms of knowledge came into existence and the social conditions that made this possible (Powell, 2001). This approach to studying gerontology can be used to understand social relations between professionals (such as social workers) and older people. For Foucault, the expert “gaze” constructs individuals as both subjects and objects of knowledge and power (Foucault, 2003, p. 54). The identities of older people and old age itself have been constructed through discourse around expiration, deterioration, and decomposition and the “gaze” helps to exaggerate management over older people in an effort to normalize and provide treatment for such concept (p. 54). With this theory in mind, social work can play a key role in assisting the elderly to receive the care they require, while simultaneously utilizing best practice methods. I believe social workers practicing in gerontological settings can be advocates in policy-making procedures that serve to enhance a positive quality of life for their clients, especially for women who encompass the bulk of seniors in long-term care. For social workers practicing in long-term care settings it may be advantageous to familiarize oneself with policies and procedures that are used in the treatment of the elderly. Perhaps more group therapy sessions, self-help groups, and increased individual treatment would be valuable in serving their clients’ best interests, especially if they are suffering from a mental health issue or if they are lonely, which several of the residents expressed to me that they were.

Chapter Fourteen: Conclusion

Studies exploring white Anglophone-Canadian-born working-class women's experiences in long-term care are extremely limited. There is a glaring gap in knowledge pertaining to this racial/socioeconomic group. Given that women tend to comprise the majority of long-term care recipients and live longer than men, it is important that issues pertaining to their satisfaction in long-term care be explored (Hankivsky et al., 2004). I endeavoured to discover what attributes help with a positive experience in long-term care by undertaking a 560 hour practicum at Extendicare Bayview in Toronto, Ontario. Specifically, I wanted to achieve a greater understanding of the significant issues affecting white Anglophone-Canadian-born women from working-class backgrounds residing in a long-term care facility.

With their written consent, I conducted a series of informal interviews with 3 lucid women selected from a pool of Marcy Turkel's (practicum supervisor) clientele. Inspired by auto-ethnography, a qualitative approach to data gathering and analysis, I was able to reflect upon my own experiences as a white Anglophone-Canadian-born woman from a working-class background while conducting my interviews and examining my compiled information, using a thematic analysis. As a result of my interviews, it was concluded that the experience of residing in long-term care in a privately-owned facility in Ontario is a positive one. A variety of activities free of cost to residents; quality prepared and served meals; an opportunity to utilize skills and talents; helpful staff; and a one-level building were important factors in my participants' quality of life in long-term care.

As discussed in my interviews, loss of independence, loved ones and privacy are issues affecting the quality of life for those living in a long-term care environment. Perhaps exploring this should be considered and suggestions made to improve these challenges. For instance, maybe a private room could be reserved occasionally for family, friends and residents needing privacy. Further, social workers can help their team members understand the issues affecting their clients, educating others on how to approach this unique clientele, while increasing the dignity of those who feel they have lost their independence as a result of residing in a long-term care institution. This may be achieved through group work among the residents as Solomon and Zinke (1992) recommend, as well as by facilitating activities that will enhance the self-esteem of those experiencing issues of loss of independence, privacy, friends, and family (McMullin & Cairney 2004). These activities may include mind exercises that help keep ageing persons mentally sharper, such as board games, reading groups, and live performances, all of which are available at Extendicare Bayview (Gatz, 1995). With increased awareness of the issues affecting our rapidly ageing Canadian population, we as a society can unite in ensuring our elderly are cared for in a way that is mindful of their experiences and contributions to our world, for as Eleanor Roosevelt once said: “beautiful young people are accidents of nature, but beautiful old people are works of art” (Haber, 2007, p. 387).

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Appendix A

Information Sheet

Dear Potential Participant,

My name is Christina Mack and I am a Master of Social Work student at the University of Northern British Columbia (UNBC). I am working on a project entitled *Anglophone-Canadian-Born Working-Class Women in Eldercare*.

The principle objectives of my project are: to contribute to a greater understanding of white Anglophone-Canadian-born working-class women's lived experiences in long-term care, to explore some of the challenges of adapting to life in a long-term care setting, to consider these challenges of transition within a feminist framework, and to make recommendations for social work education, policy, practice, and research in this area.

In an effort to enhance my skills, I kindly request that you participate in the formulation of my practicum report. I would like to engage in informal conversations with you at a time that is convenient for you. I would like to know about your experiences as a resident of Extendicare. I would like to know about your general thoughts, views, opinions, and experiences as a white Anglophone-Canadian-born woman from a working-class background. I have selected you to partake in my practicum report because your thoughts, views, opinions, and experiences are important and valuable to me and I am confident that your story will add a degree of quality to my exploration of women in eldercare.

It should be noted that there are potential risks and benefits involved in participating in the formulation of my practicum report. First, it should be known that disclosure of any incident(s) of mistreatment, neglect, or possible harm that may put you or another resident of Extendicare Bayview at risk must be reported by me to Marcy Turkel, Social Worker. Further, possible risks may include adverse reactions/feelings which may arise when recalling past events in your life, and/or issues you may anticipate assistance with at Extendicare Bayview, that I am unable to provide in my role as a student. Regarding benefits, your participation in my report may provide invaluable information for the enhancement of the quality of life for both current and future residents, not only at Extendicare Bayview, but at long-term care facilities across the province.

Participation in this project is strictly voluntary. If at any time during our conversations you wish to stop and/or withdraw your participation, you may do so at any time without consequence. Any information you have shared will be shredded on your withdraw date and will not be included in my final report. Pertinent points of our conversations will be written out by me and, if used in my practicum report, referenced as "personal communication", citing the date we spoke. You may take out parts of what you have said at any time. Your identity will remain confidential. I will not use your real name or disclose your identity in my project. Forms, conversation notes, and any other personal information will be kept by me in a secure, locked file cabinet, until they are destroyed by shredding in December 2008. The only other person who has my permission to access this information will be my academic supervisor at UNBC, Dr. Si Transken. You may contact her at 250-960-6643 with any questions or concerns you may have.

A copy of this project will be available at the UNBC library in Prince George, BC. If you have any questions or comments regarding this project, please contact me at 416-832-7035. Any concerns or complaints regarding this project should be directed to the UNBC Office of Research at 250-960-5820.

Sincerely,

Christina Mack

APPENDIX B**LETTER OF INFORMED CONSENT**

MSW Practicum Report

Student: Christina Mack, BSW

Research Title: Anglophone-Canadian-Born Working-class Women in Eldercare

I, _____,
resident of Extendicare Bayview, 550 Cummer Ave. Toronto, Ontario, hereby consent to voluntarily participate in Christina Mack's research regarding white Anglophone-Canadian-born working-class women in eldercare. I understand that Christina Mack is a Master of Social Work student seeking my consent to collect and use my information on the following conditions:

1. I understand that I have been asked to be interviewed for an MSW project and have agreed to do so;
2. I understand that consent forms, session notes, and any other personal information will be kept by Christina Mack in a secure, locked file cabinet.
3. I understand that my name and personal information will be kept confidential;
4. I understand that I may contact Christina Mack should I have any questions or concerns about my participation in this research;
5. I understand that I can refuse to sign this consent form. I also understand that I am free to refuse or withdraw from the research at any time and that there is no consequence for me doing so.

The participant and researcher have discussed each of the conditions and have agreed with them.

Signature of Participant

Date